

The Behavioral Health Assessment and Service Plan: Improving Quality and Enhancing Interagency Connectivity

Session Purpose

To provide key agency partners with an overview of recent changes ADHS-DBHS has made in the assessment and service planning process as the result of a year-long strategic initiative.

Overarching Goal of Initiative

To provide a wide array of behavioral health services supported by a system that is:

- Person/family centered
- Culturally competent
- Strength-based
- Outcome-based
- Timely and efficient

A Collaborative Effort

Over 100 stakeholders (providers, family members, consumers, other agency representatives) participated in:

- Weekly clinical workgroup meetings
- Quarterly status meetings
- Assessment design workshops
- Review and revision of documents
- Pilot testing

The Major Changes

- Standardized the referral process
- Revised intake forms and procedures
- Incorporated use of teams and clinical liaisons
- Standardized / streamlined assessment, service planning and annual update processes
- Modify assessment and service planning timelines
- Allow additional qualified clinicians to complete assessments

Points of Interagency Connectivity

There are opportunities for interagency contact and coordination within the:

- Referral process
- Teams and the Clinical Liaison
- Assessment and service planning process

The Referral Process

Policy has been revised to ensure

- A welcoming and engaging process
- Identification of urgency of need
- Timely follow up on referral
- Enhanced communication with referral source

Identifying Strengths

- Key to moving away from a deficit-based approach
- Must be woven through the entire process
- Can only be obtained thorough dialogue and probing

Identifying Strengths

4 components:

- Identifying the person's internal strengths
- Determining how to apply those internal strengths to activities
- Identifying the family's strengths
- Identifying other people who support the person/family

Cultural Competency

- What it is

- An interviewing skill and understanding that individuals may be defined by a group in which they feel a part
- Results in a more comprehensive picture and understanding of person/family
- Assists in identification of strengths/supports, development of service plan and measurement of progress

- What it isn't

- Not only for minority persons
- Does not require learning about every ethnic group
- Should not result in assumptions being made based on culturally rooted stereotypes

Cultural Competency

- Why it's important
- Cultural considerations
- Resources for skill building
 - Cultural Competency Training
 - Other Resources:
 - SAMHSA – www.samhsa.gov
 - HRSA Office of Minority health – www.hrsa.gov/omh
 - Kaiser Family Foundation – www.kff.org
 - Western Interstate Commission for Higher Education – www.wiche.edu
 - National Center for Cultural Competence – www.georgetown.edu

IV - Clinical Liaison and The Team

Clinical Liaison Philosophy

The Clinical Liaison refocuses the role of the Assigned Clinician to support a strengths-based, family friendly, culturally sensitive, clinically sound and supervised service delivery model.

The Team

- Individuals working together who are actively involved in a person's assessment, service planning and service delivery.
- Linchpin of person/family centered practice that is:
 - Inclusive
 - Coordinated
 - Flexible
 - Person/family driven

Team Composition

- Child and Family teams must include the person, the parents/ guardian and a behavioral health representative
- Adult teams must include the person and a Clinical Liaison
- May include others chosen by person (and parents/guardian) e.g. friends, family members, teachers, CPS workers, DDD case managers, parole officers

Duties of Team

- Explores and documents strengths and needs of the person and family
- Establishes and prioritizes service goals
- Identifies supports
- Develops a written service plan
- Monitors progress
- Determines responsibilities for team members

Keys to being an effective Team

- Creating a welcoming, engaging, supportive environment
- Striking a balance between what the person/family wants and what is clinically sound
- Maintaining timeliness and efficiency

The Clinical Liaison

- Is assigned to each person
- As part of the initial intake/assessment process:
 - Conducts initial assessment
 - Ensures next steps identified in interim service plan are completed
 - Acts as initial point of contact
- May change over time
- Ensures continuity
- Must be credentialed and privileged

Credentialing and Privileging

Credentialing required for:

- All Behavioral Health Professionals (BHPs)
- Behavioral Health Technicians (BHTs) with a minimum of AA degree and required course work and work experience

Privileging requirements include:

- BHTs and BHPs must complete this training
- BHTs must also complete Enhanced Assessment training and 3 supervised Assessments

Clinical Liaison Duties

- Collects, analyzes and synthesizes information
- Provides clinical oversight to Team
- Ensures clinical soundness of assessment and service planning process
- Works in collaboration with person and Team and explains clinical options
- Serves as central point of contact
- Maintains the medical record
- May serve in other capacities on the Team

Assessment and Service Planning Principles

- Are developed with unconditional commitment to enrolled persons and families
- Begin with empathetic relationships that foster ongoing partnerships, respect and equality
- Are developed collaboratively with families to engage and empower unique strengths

Assessment and Service Planning Principles

- Include other individuals important to the person
- Are individualized, strength-based, culturally appropriate, clinically sound
- Are developed with the expectation that the person is capable of positive change, growth and leading a life of value

Assessment Approach

- Same tool used for all populations
- Divided into two components: The Core and The Addenda
- Trigger questions are utilized
- Initial assessment must be completed in 45 days
- Assessment is an ongoing process

II - Intake

- Cover Sheet
- Data Collection and Reporting

The Core Assessment: Purpose

To collect enough information to ensure safety and to get the person to the appropriate next service(s) in a timely manner

The Core Assessment Includes

- Presenting concerns
- Behavioral health & medical history
- Criminal justice history
- Substance related disorders
- Abuse/sexual risk behavior
- Risk assessment
- Mental status exam
- Clinical formulation & diagnosis
- Next steps/interim service plan

Behavioral Health & Medical History Questionnaire

- Completed by person/family prior to Assessment or by Assessor during interview
- Collects information about:
 - Current and past medical concerns and treatment for person
 - Current and past behavioral health services for person and family

Presenting Concerns

- Serves as the “heart” of the assessment.
- Encourages persons to say in their own words what they want to accomplish
- Provides a context to develop service and discharge planning

Criminal Justice

- Used to identify those person who are or were involved with the criminal justice system
- An affirmative answer to trigger question requires completion of Criminal Justice Addendum

Substance Related Disorders

- To identify persons who may be involved with alcohol or drugs
- To establish a DSM diagnosis for abuse/dependence for those persons
- To design a mix of settings and services that will support long-term sobriety and recovery

Example of Completed Table for Question B.3

Substance Use in Past 12 Months (please circle)	Freq. (use code below)	Route (use code below)	Age First Used	When Last Used	Current Use (past 30 days) Primary (P) or Secondary (S)
Alcohol	4	1	10	Yesterday	S
Marijuana	5	2	11	Today	P
Stimulants ▪ Methamphetamine ▪ Cocaine/crack ▪ Other (e.g., Ritalin, amphetamine)	2	2	11	Two weeks ago	
Opiates/Narcotics ▪ Heroin ▪ Other (e.g., codeine, hydrocodone, oxycodone, oxycotin, propoxyphene, non-prescription methadone)					
Depressants ▪ Benzodiazepines (e.g., Valium, Klonopin, Ativan, Xanax, Halcion) ▪ Other sedatives, tranquilizers hypnotics (e.g., Soma, Benadryl, barbiturates)	3	1	25	Last Week	
Hallucinogens: LSD, PCP, MDM A, shermes, ecstasy, ketamine, psilocybin, etc.					
Inhalants: glue, paint, gasoline, other solvents/aerosols, etc.					
Other Drugs: non-narcotic analgesics, GHB, other/unclassified and other medications used in excess of prescription [e.g., Prozac, Haldol, Robitussin]. Specify type:_____					

Codes for Table

Frequency of Use/Abuse:

- 1 No use in past 30 days
- 2 1-3 times in past 30 days
- 3 1-2 times per week
- 4 3-6 times per week
- 5 Daily/multiple times per day

Route of Administration:

- 1 Oral
- 2 Smoked
- 3 Inhaled
- 4 Injected
- 5 Other (specify in table)

Abuse/Sexual Risk Behavior

To determine:

- Safety of the person's home environment
- Risk of physical, sexual or emotional abuse
- If abuse is currently occurring

Risk Assessment

- To determine the person's overall ability to be safe in the community
- To assess the need for immediate intervention balancing all known factors

Mental Status Exam

- Summarizes observations and impressions of the person
- Provides a description of the person's speech, appearance, activities, thoughts and attitudes during the interview process

Clinical Formulation and Diagnosis

Is the bridge between the Core Assessment and the Service Plan

- Summarizes information gathered in Core Assessment
- Makes one or more provisional DSM diagnoses and summarizes other diagnostic factors
- Includes GAF scores for both adults and children to indicate person's overall level of functioning

Next Steps/Interim Service Plan

Provides a way to:

- Organize and document the steps to be taken by the provider and the person/family
- Triage the person/family to the most appropriate next service
- Select an array of services that will be put in place until the full assessment is completed

Example of Completed Interim Service Plan

<u>Description</u> of Next Steps (Action) to Be Taken	<u>Who</u> Will Be Responsible to Ensure Action Occurs	<u>Where</u> Action/Step Will Take Place (e.g., provider)	<u>When</u> Action/ Step Will Take Place
1. Contact PCP and arrange for an appointment for medical concerns identified during the assessment.	Ann Smith, Clinical Liaison and Joan	Appointment will occur at PCP Office on Osborn Street.	Apt will be scheduled today and held within 7 days.
2. Joan will discuss potential participation in service planning with her husband and mother and call Ann to notify her when this has been done.	Joan will invite family and notify Ann Smith.	Joan will make the invitation after dinner this evening.	This evening.
3. Ann will arrange the next appointment including family members and will also schedule a psychiatric appointment for the same day.	Ann Smith	The next appointment will occur at the 24 th Street Clinic.	Within 23 days.
4. Joan will attend PCP appointment and will bring the results to the psychiatric appointment.	Joan	PCP Office and 24 th Street Clinic.	Within 23 days.
5. Joan will begin to keep a record of her eating and sleeping patterns and other symptoms of depression using the Hamilton Depression Inventory. Joan will also keep a list of activities that she enjoyed doing between her clinic visits.	Joan	At her home and at work.	Begin today and report at next meeting.

The Assessment Addenda

Addenda are to be used to:

- Examine life domains of the person
- Build a more complete picture of the person/family
- Identify the impact of the Presenting Concerns on functional life areas
- Identify further strengths and supports
- Lay a foundation for a Child and Family Team's Strengths and Cultural Discovery

The Addenda Include

- Living Environment
- Family/Community Involvement
- Educational/Vocational Training
- Employment
- Developmental History
- Criminal Justice
- SMI Determination
- Child Protective Services

Living Environment

Assists in gaining understanding of:

- The support system the person has developed
- The person's day-to-day stressors
- How the person copes with activities of daily living

Family/Community Involvement

Assists in:

- Getting to know the person outside of the symptoms and diagnostic checklists
- Identifying the person/family's strengths
- Laying a foundation for the Child and Family Team's Strengths & Culture Discovery process

Educational/Vocational Training

- Assess other areas where there may be success or difficulties
- Reveal strengths, skills and interests as well as long-range goals
- Help round out what the person does all day
- Suggest possible collaborators, supports and resources

Employment

- Assists in understanding the person's ability to hold a job, attitude about working, and overall impact of employment on his/her life
- Identifies strengths that can be used in moving toward recovery
- Identifies difficulties in getting or keeping employment or in functioning in some settings

Developmental History

- Understand and document key elements of the person's social, emotional and physical skill development
- Identify possible developmental problems and the need for further assessment
- Provide an objective description of the person's abilities and deficits
- Determine eligibility for programs
- Assist in planning for appropriate interventions

Criminal Justice

- To collect more in-depth information about criminal justice history and/or current trouble with law

SMI Determination

- To ensure prompt and accurate identification of persons with a serious mental illness (SMI)

Child Protective Services

- Determine the status of a child in the midst of crisis
- Assess the child
- Support the child by mitigating the trauma of removal and providing appropriate immediate intervention
- Obtain information to help CPS case manager and the Court

The Behavioral Health Service Plan

Ongoing process that:

- Provides direction to person, family and team on steps to meet person's needs
- Assesses progress in meeting measurable objectives
- Encourages involvement and achievement, building on strengths of person/family

Initial plan developed within 90 days of initial appointment

A Service Plan Includes

- Recovery Goal/Person-Family Vision
- Person's Strengths
- Identified Needs and Specific Objectives
- Measures (Current, Desired and Achieved)
- Interventions to Objectives
- Review of Progress

Individuals at Service Planning Meeting: Ralph Magee; Maxwell Jones, Clinical Liaison; Mrs. Magee, Mother; Mr. Magee, Father; Adriana Smith, CM; Willow Martinez, Rehab Specialist; Carrie McGuire, RN; Ed Vance, Team Lead and Sandy Baker, Housing Specialist

RECOVERY GOAL/PERSON-FAMILY VISION:

Ralph wants to increase his independence and social activities: I want to have my own apt (or share one with a friend), maintain my sobriety and have a job that I like (using my hands).

PERSON'S STRENGTHS:

Ralph is motivated, sober, has good basic independent living skills (ILS, within current living arrangement with family, likes to build model airplanes and is good with engines, has his own bank account, knowledgeable of the bus system, worked part time previously, has transferable job skills, attends church with family and found Latino AA Groups to be beneficial in the past.

Target Date for Meeting Objectives: 9/25/03

IDENTIFIED NEEDS and SPECIFIC OBJECTIVES (to address these needs)	Current Measure	INTERVENTIONS to MEET OBJECTIVES		Desired Measure	Achieved Measure (at target date)	Measure Met (Y/N)
		Specific Services and Frequency	Strengths Used			
Housing: obtain own or shared apartment 1. Improve budgeting and set up savings plan 2. Identify potential housing options 3. Obtain information on Roommate Matching program 4. Apply to desired Program(s). 5. Contact his church Pastor to inquire about housing and roommate opportunities within the congregation. 6. Adriana and Sally will assist Ralph with applying for housing service, Section 8, as well as the Roommate Matching program.	1-5: 0	1. Adriana will contact the living skills specialist by 8/26/03 to schedule budget training meetings(s) 2. Meet with Adriana and Sally by 9/10/03 3. Sandy will meet with Ralph by 9/10/03 4. Complete applications by 9/25/03 5. Call by 9/15/03	Knows and uses bus system Church involvement and support Has own bank account. Personable – can get along with potential roommates Good basic ILS. Housing specialist and CM active part of Team	1. 1-2apts 2. 1 apt. 3. 1 apt. 4. 1 apt 5. 1-2 calls/apts.		
Part-time job working with his hands, near a bus-route. 1. Write a resume with Willow's assistance 2. Take the bus to the One-Stop Center and look for available job position that he is interested in applying for	1-3: 0 4. 1	1. Rehabilitation services: 2-3 meetings. 2. One-Stop Center trip	High interest in working and having own money.	1. 1-2 apts. 2. As		

Annual Behavioral Health Update and Review Summary

- Describes the significant events in a person's life over the year and how person/family responded to services/treatment
- Highlights the person's ongoing service needs, cultural preferences/considerations for services, current functioning, risk factors, and diagnostic information
- Identifies what supports/services were helpful and what changes need to be made

Resources

Assessment and service planning policies and tools can be found on the ADHS-DBHS website:

www.hs.state.az.us/bhs

**Process Improvement +
Enhanced Interagency
Connectivity =
Better Outcomes**